Flexpro™

Section
125
Flexible Benefits

State of Indiana

Employee Enrollment Information Packet

· What is FlexPro™?
· Is A Flexible Spending Account Right For You?
· How Flex Works
· What Type of Expenses Are Eligible?
· Tax Savings Worksheet - Find Out How Much You Can Save
· Flexible Spending Accounts Frequently Asked Questions
·MBI Benefits Card (Flex Card) and Claims Procedure
·Employee On-Line Access to MBI - Member Account Set Up
· Claim Form
· Plan Specifics Page
· Election Form / Salary Reduction Agreement

Key Benefit Administrators P.O. Box 55210 Indianapolis, IN 46205 800-558-5553

What is *FlexPro*?

FlexPro™ is a Flexible Benefits (Cafeteria) Plan that is approved under Section 125 of the Internal Revenue Code. It enables you to pay for certain expenses with pre-tax dollars.

Optional Benefits*:* (Some or all of the these benefits may be offered by your employer)

Employee Paid Insurance Premiums — This account automatically allows you to pay for your portion of some insurance premiums with tax-free dollars. This may include premiums for medical, dental, vision, group term life, cancer, etc.

Health Care Flexible Spending Account (FSA) — Health care costs include medical, dental, vision and hearing expenses that are not paid by insurance and other "out-of-pocket" expenses. These expenses must be incurred within the plan year. These expenses may include, but are not limited to: expenses for medical plan co-payments, deductibles, prescriptions, physician visits, chiropractic care, vision, dental/orthodontia care, and eligible over-the-counter items.

Dependent Day Care Flexible Spending Account (FSA) — Dependent Day Care costs include most dependent day care expenses for eligible children and adults. Qualified expenses include fees for adult and childcare centers, pre-school, and before and after school care. To be eligible you and your spouse (if married) must be employed or attend school. Your dependent must be under age 13 or physically and/or mentally incapable of caring for him or herself. As of each regular deduction date established by the Plan during a Plan Year, the Employer will credit an amount to each Participant's Plan Year Account for the corresponding amount by which the Participant's cash compensation has been reduced pursuant to his election under the Plan. Eligible claims incurred during the Plan Year and submitted within the appropriate timeframe shall be reimbursed up to the amount available in the account at the time of reimbursement

Is a Flexible Spending Account Right For You?

	YES	NO
Do you have out-of-pocket costs associated with your employer's medical plan? (i.e. co-payments, deductibles, co-insurance)	☐	☐
Do you have other out-of-pocket medical care expenses not covered by insurance?	☐	☐
Do you have out-of-pocket dental expenses? (i.e. cleanings, fillings, orthodontia, etc.)	☐	☐
Do you have out-of-pocket vision expenses? (i.e. exams, glasses, contact lenses, LASIK, etc.)	☐	☐
Do you have Child Day Care Expenses that allow you and your spouse (if married) to be gainfully employed or attend school.	☐	☐

If you answered **YES** to any of these questions, you can reduce the taxes that you pay by participating in your employer sponsored Flexible Benefits Plan, ***FlexPro***, and therefore **increase your take home pay!**

How Flex Works

	Without Flex	With Flex
Annual Income	$ 30,000	$ 30,000
Out-of-Pocket * Pre-Tax Expenses	$ 0	$ 3,000
Remaining Income To Be Taxed	$ 30,000	$ 27,000
Estimated Taxes (26%) FICA, Federal & State **	$ 7,800	$ 7,020
Out-of-Pocket After-Tax Expenses	$ 3,000	$ 0
Take Home Pay	$ 19,200	$ 19,980
YOUR ANNUAL TAX SAVINGS	$ 0	$ 780

Please Note: **The example shown above is for illustrative purposes only.**

* *The expenses in this example include Insurance Premiums, Health Care FSA and Dependent Day Care FSA.*
****** *Varies According to State Regulations*

The above example illustrates the advantage of participating in your employer's Flexible Benefits Plan. This Illustration demonstrates how a participating employee might save $780 in taxes during the Plan Year by paying for his expenses with pre-tax dollars.

How Much Can I Save?

Employee Tax Savings Worksheet

I. Health Care FSA Expenses:

Estimated family annual medical/dental/vision expenses **not covered** by insurance:

Co-pays, deductibles, co-insurance	$ _____
Prescription drugs	$ _____
Over-the-counter drugs/medicines	$ _____
Doctor office visits	$ _____
Physical exams	$ _____
Well-baby care	$ _____
Chiropractic care	$ _____
Dental care	$ _____
Orthodontia	$ _____
Vision Exams	$ _____
Eyeglasses, Contact lenses, solution	$ _____
Insulin and related supplies	$ _____
Hearing care	$ _____
Other Medical Expenses	$ _____

Total Annual Medical, Dental, Vision Expenses: $ _____

II. Dependent Day Care FSA Expenses

Weekly expenses $ _____

x 52

Total Annual Dependent Day Care Expenses: $ _____

III. Total Flex Savings

Total eligible annual expenses from above $ _____

Multiply by an estimated tax savings of 26% x 26%

Your Estimated Annual Tax Savings: $ _____

Flexible Spending Accounts * Frequently Asked Questions

This packet is only a brief overview of benefits that may be eligible under your plan. You should consult your Summary Plan Description for specific information about your plan.

Who can participate in the Plan?

All employees who have met the eligibility requirements established by their employer may participate in the Plan.

How do I sign up?

Your employer will give you the opportunity to sign up prior to each effective date of the Plan, provided you have fulfilled the eligibility requirements.

How do I determine how much money to allocate?

Be conservative! Only consider your known expenses. Do not allow for things that might happen. For dependent day care, do not forget to consider vacations or times you will not be paying the dependent day care provider. A list of eligible expenses and a worksheet are provided to help you calculate your expenses for the upcoming plan year.

Are there limits?

Yes, the maximum annual amount for the Dependent Day Care FSA is $5,000 ($2,500 if you are married and filing separate tax returns). The maximum annual amount for the Health Care FSA is printed in your Summary Plan Description.

I went to the doctor before the plan year began, but I did not pay the expense until after the plan year started. May I include that expense?

No. Services must be incurred within the plan year. The date of payment does not matter.

Can I change my annual allocation anytime during the Plan Year?

You may change your annual allocation if you have one of the eligible status changes as defined in your Employer's Plan. Examples of qualifying changes in status are marriage or divorce, death of a spouse or dependent, birth or adoption of a child, and change in your employment or in your spouse's employment. Status changes must be consistent with the status change event. Please consult your Summary Plan Description for complete details.

What happens if I do not use all of my annual allocation?

The IRS has established a "use it or lose it rule." If you do not use all of your annual allocation, you will forfeit any remaining amount. For example, if you allocate $500 and only submit $450 in expenses, you will lose the $50 (not just the taxes.) So, please be conservative when you determine your annual allocation.

Does my plan include a Grace Period?

The IRS recently issued a new regulation governing Section 125 Flexible Spending Plans. It allows employers to extend the deadline for participants to *incur* claims for their Flex Plan (medical and dependent daycare) after the end of the plan year. See the Plan Specifics.

Point of Sale transactions automatically come out of the previous year if there are funds available. If there are no funds available in the previous plan year, the transactions will come out of the new plan year. If you have $10 available in the previous plan year and the charge is $20, it will take the $10 out of the previous plan year and the remaining $10 out of the new plan year.

Can I sign up for the Dependent Day Care plan and still take the Dependent Day Care tax credit on my annual tax return?

The amount you pledge towards the Dependent Day Care account reduces the amount you can claim as a tax credit, dollar for dollar. Most employees (depending on your family income) will experience a higher tax savings on the Dependent Day Care Plan. You should consult with your accountant to see which option works best for your situation.

What happens if I terminate my employment?

You may still submit eligible receipts for expenses incurred within the time frames established by your Employer. Also, you may be eligible to continue coverage under the Health Care FSA option through federal COBRA regulations.

How do I submit a claim for reimbursement?

Copies of receipts for Health Care FSA expenses must be submitted with a signed claim form. The receipts must be independent third party receipts showing the name of the provider, the date of service, the type of service, the amount of the service and the patient's name. If your insurance company covers the expense, please submit the receipt to the insurance company first. You may then forward a copy of the Explanation of Benefits from the insurance company along with the signed claim form to FlexPro™. Cancelled checks are not eligible as receipts for Health Care FSA expenses. The total amount of reimbursement you selected for the Plan Year will be available at all times during the Plan Year.

For Dependent Day Care FSA expenses, send a signed claim form along with copies of statements or receipts, which show the day care provider's name, the dates of service, the amount of the service and the dependent's name to FlexPro™. Reimbursement of expenses incurred during the Plan Year shall not exceed the balance of your Plan Year Account at the time of the reimbursement.

Claim forms, including detailed receipts/invoices, may be faxed for processing to (317) 284-7269 or (866) 241-1488.
.

Will I receive information throughout the year telling me where I stand on my account?

Yes, you will receive periodic reports showing what has been credited to your account. You will also receive a reminder letter before your plan year ends, if you have a balance in your account.

Will my participation in the Flex Plan affect my Social Security?

You will not pay Social Security taxes on the money you contribute to the Flex Plan. Therefore, your future Social Security benefits may be slightly reduced. However, the tax savings you receive from this plan should be more than any reduction in your Social Security benefits.

What Type of Expenses Are Eligible?

Health Care FSA Expenses

The following list, while **not intended to be complete**, illustrates expenses that **may** be reimbursed under the Health Care FSA; restrictions may apply.

CO-PAYMENTS / DEDUCTIBLES / CO-INSURANCE
PRESCRIPTION AND OVER-THE-COUNTER (OTC) DRUGS AND MEDICINES *(Expenditures for medical care – to treat or alleviate personal injuries or sickness.* ***OTC reasonable quantity limitations may apply****.)*

DENTAL EXPENSES
- Routine & Preventive Services
- X-rays
- Orthodontia *(generally as treatment is provided)*
- Restorative services, fillings, extractions, dentures

VISION CARE EXPENSES
- Eye exams
- Prescription eyeglasses & sunglasses
- Contact lenses & supplies
- Corrective surgery *(RK & LASIK)*

MEDICALLY NECESSARY EQUIPMENT
- Wheelchair, crutches & lifts
- Oxygen equipment & supplies
- Blood pressure monitor

DIABETIC SUPPLIES
- Insulin
- Test strips, lancets, etc.
- Glucose monitor

PHYSICAL EXAMINATIONS
- Annual physical exam *(including prostate screening, pap smears & mammograms*)
- School & work physicals

COUNSELING & PSYCHIATRIC TREATMENT
(Prescribed by a doctor to treat a medical condition.
Statement required from the doctor. See Marriage/Family Counseling)
- Psychologists
- Psychotherapists
- Psychiatrists

FEES & SERVICES
- Physicians, surgeons, anesthesiologists, OB/GYN
- Ambulance
- Nursing *(including room & board)*
- Chiropractic services
- Fertility treatment
- Sterilization & reversals
- Medically necessary reconstructive services *(i.e. mastectomy or following an accident)*
- Hospital expenses

HEARING EXPENSES
- Testing
- Hearing aids
- Batteries & repairs

OTHER EXPENSES
- Prosthesis & artificial limbs
- Organ tissue donation expenses
- Tuition at special school for handicapped
- Travel necessary to seek medical treatment *(limitations apply)*
- Orthotics & orthopedic shoes *(medically necessary)*
- Laboratory fees
- Acupuncture
- Alcohol & drug rehabilitation expenses
- Special equipment for those who are deaf and/or blind *(i.e. Braille books, hearing devices, guide dogs)*
- Weight loss programs and drugs *(when prescribed by a doctor to treat obesity and/or a medical condition – statement required from the doctor)*
- Smoking cessation program or prescribed drug
- Medical supplies
- Therapy treatments *(when prescribed by a doctor)*

The following list illustrates some of the Health Care expenses that are NOT ELIGIBLE under the Plan:

- Cosmetic treatments or surgery *(unless necessary to alleviate a deformity related to a congenital abnormality, trauma, or disfiguring disease)*
- Expenses *(treatments and drugs)* only to improve your general health or well being
- Hair replacement treatments and drugs
- Health club dues
- Long Term Care Insurance
- Marriage & family counseling
- Nutritional supplements
- Teeth whitening
- Vacations
- Vitamins to improve or to preserve general health *(even when prescribed by a doctor)*

  Weight loss programs and drugs to improve or to preserve general health *(even when prescribed by a doctor)*

Dependent Day Care FSA Expenses

Dependent Day Care FSA ELIGIBLE expenses include expenses necessary for you and your spouse (if married) to be gainfully employed or attend school. Eligible expenses include:

- Expenses paid for the care of a dependent under age 13
- Expenses paid for the care of a dependent who is physically or mentally incapable of caring for himself or herself
- Expenses paid to a dependent day care provider
- If you are divorced your child must be in your custody for at least six months out of the year

The following list illustrates some of the Dependent Day Care expenses that are NOT ELIGIBLE under the Plan:

- Kindergarten
- Field trips, lunches, supplies, and transportation fees
- Overnight camps
- Care for dependent that lives outside of the employee's home
- Registration fees

Over the Counter Drug Reimbursements

APPROVED BY THE IRS

*The IRS has approved some over-the-counter, non-prescription, "medicines and drugs" that are taken for medical care as eligible expenses for reimbursement under your Health Care Flexible Spending Account (FSA). "Medicines and drugs" are defined as items for your personal use (or your spouse or dependents) to alleviate or treat personal injuries or sickness. Still **not** eligible are items merely beneficial to your general health such as dietary, nutritional supplements, vitamins, toothpaste, etc.*

Examples of Eligible Expenses

(The following list, while not intended to be complete, illustrates some over-the-counter expenses that may be reimbursed under the Health Care FSA; some restrictions may apply and may require a letter of medical necessity from a physician.)

Allergy Medicine
Antacids
Anti-diarrhea Medicine
Bactine
Band-Aids/Bandages
Bug Bite Medication
Calamine Lotion
Carpal Tunnel Wrist Supports
Cold Medicines
Cold/Hot Packs for Injuries
Condoms
Contact Lens Cleaning Solution
Cough Drops
Diaper Rash Ointments
First Aid Cream
First Aid Kits
Hemorrhoid Medication
Incontinence Supplies
Laxatives
Liquid Adhesive for Small Cuts
Menstrual Cycle Products for pain and cramp relief
Motion Sickness Pills
Nasal Sinus Sprays or Strips
Nicotine Gum or patches for Stop-smoking Purposes
Pain Reliever
Pedialyte for Ill Child's Dehydration
Pregnancy Test Kits
Products for Muscle Pain or Joint Pain, i.e., Ben Gay, Tiger Balm, etc.
Reading Glasses
Rubbing Alcohol
Sinus Medications
Sleeping Aids used to treat occasional insomnia
Special Ointment or Cream for Sunburn
Spermicidal Foam
Thermometers (ear or mouth)
Throat Lozenges
Visine and other such eye products
Wart remover treatments

MBI Benefits Card (Flex Card) and Claims Procedures

You may use your MBI Benefits Card™ (Flex Card) for eligible FSA expenses such as co-pays, deductibles, out-of-pocket expenses, and other expenses that are not eligible under your medical, dental or vision plan but are eligible FSA expenses.

1. What is the MBI Benefits Card?

The MBI Benefits Card™ (Flex Card) is a MasterCard offered to enhance your Flexible Spending Account by providing instant access to your FSA account. The card is designed for use only at qualified providers or merchants that accept MasterCard and offer eligible goods or services for reimbursement under your Flexible Spending Account. Rather than paying out-of-pocket money for qualified expenses and waiting for reimbursement, your Flex Card transfers funds for qualified expenses directly from your available funds in your Flexible Spending Account to the provider. As a Flexible Spending Account participant, a Flex Card will be mailed to your home address.

2. How does the Flex Card work?

The Flex Card is a debit card that allows you to pay for your eligible FSA expenses directly at the point of service. The Flex Card is treated like a credit card at a merchant or provider terminal because it does not require a P.I.N. number before processing a transaction. There is no additional line of credit associated with the card, and no credit check will be performed.

3. Substantiation Requirements.

a. Substantiation Request – In order to confirm the eligibility of all expenses charged to your Flex Card, you may be asked to provide supporting information about your purchase. *FlexPro* follows the IRS-defined Flexible Spending Account Flex Card audit guidelines.

Although the Flex Card provides direct access to your FSA dollars, it does not eliminate the need for your FlexPro Administrator to verify the eligibility of the item(s) purchased as requested by the IRS.

The following substantiation criteria is required.

Substantiation Requirements

1. **Name of Patient**
2. **Date of Service or purchase**
3. **Name of Provider or Merchant**
4. **Type of Service or Supply**
5. **Amount of Service or Supply**

b. Co-Payment Drug Store/Pharmacy – The Flex Card may be used at many Drug Stores/Pharmacies such as: Walgreens, CVS, Longs, Eckard, Your Hometown DrugStore/Pharmacy (This list is not all inclusive).

When your total Flex Card purchase is for an amount exactly equal to your employer's prescription co-payment (up to a total of multiples of five times the maximum co-payments), no further purchase substantiation is required; however, you should still keep copies of all receipts for your personal records.

***Example #1* — Associate Substantiation Not Required** (Eligible Pharmacy Expense)

Your Drug Store/Pharmacy
14 W Drugstore Street, Hometown, IN 46260

Joe Jones PH: 317-555-5555
100 Main Street
Indianapolis, IN 46111
No. 1073278-05141 Date 05-01-06
Amoxicyllin 500 mg 30 Tabs No Refill
New $42.10 Your Insurance Saved You $32.10 **$10.00**
Plan: A10 Dr. D. Good
Group# 111111 Claim Reference# 11111111100010
NDC 1111-111-01 MFG **Pharmaceutical Company**

Joe Participant uses his Flex Card at the pharmacy to pay for his prescription. His medical plan co-pay is $10.00 for a prescription, so his total purchase at the pharmacy came to $10.00. Joe pays for this purchase with his Flex Card and is not required to provide further purchase substantiation since the total purchase exactly equaled his applicable prescription plan co-payment.

c. Co-Payment, Deductible and Other Out-Of-Pocket Expenses at the physician office or hospital. You may use your MBI Benefits Card (Flex Card) at health care related providers or merchants such as pharmacies, doctor's offices, dentist's offices, vision providers and hospitals.

When your total Flex Card purchase is for an amount exactly equal to your employer's medical plan co-payment (up to a total of multiples of five times the maximum co-payments), no further purchase substantiation is required; however, you should still keep copies of all receipts for your personal records.

***Example #2* — Associate Substantiation Required (Eligible Expense)**

Your Town Hospital **PATIENT INFORMATION: Joe Jones** **Statement Date 01-27-06**
P.O. Box 555 A0707700127 **Total Due $ 129.18**
Indianapolis, IN 46111
ADDRESS SERVICE REQUESTED

DATE OF SERVICE	DESCRIPTION	PRICE	TOTAL CHARGES
01-12-06	480 CARDIOLOGY	1119.00	
01-12-06	482 STRESS TEST	651.00	
TOTAL CHARGES			1770.00
02-15-06	DOS 01-12-06 Insurance Adjustment	478.25CR	
02-15-06	DOS 01-12-06 Insurance Adjustment	1162.57CR	

Total Account Balance/Patient Responsibility $129.18

Joe uses his Flex Card to pay for services rendered at the hospital that were incurred within his Flexible Spending plan year. The patient responsibility is $129.18. Substantiation is required since the service/purchase does not match his medical plan co-payment. Joe would receive the transaction detail request via e-mail or by mail and simply reply by faxing or mailing copies of the detailed invoice or receipt along with a completed claim form directly to *FlexPro* for review. *FlexPro* Customer Care would determine that the charges were for eligible expenses and approve his claim. Periodic reports of Joe's claim activity are mailed throughout the plan year and Joe can view his claim activity at WWW.MBICARD.COM. Please review the 'Substantiation Requirements' outlined above.

Example #3 — Associate Substantiation Required (Ineligible Expense)

Dr. Allan Nolan ***STATEMENT***
Family Practice
3701 North Everbrook Lane
Indianapolis, IN 46111

Telephone: 317-555-5552

Joe Jones PH: 317-555-5555
100 Main Street
Indianapolis, IN 46111

01-03-06	BEGINNING BALANCE	$110.00
01-03-06	INSURANCE PAYMENT	-88.00
02-02-06	ENDING BALANCE	$22.00

Please note you **may not** use your Flex Card toward **'Paid on Account' or 'Balance Forward'** charges**.** Joe would receive the transaction detail request via e-mail or by mail and simply reply by faxing or mailing copies of the detailed invoice or receipt along with a completed claim form directly to *FlexPro* for review. *FlexPro* Customer Care would determine the 'Paid on Account' or Balance Forward' statement is an ineligible receipt type. Joe would be notified that additional information is required. Joe must reimburse the plan or provide the appropriate substantiation for the purchase on his Flex Card. Joe's Flex Card would be temporarily deactivated if repayment is not received immediately by *FlexPro* or sufficient eligible traditional claims are submitted to offset the ineligible Flex Card charges. Please review the 'Substantiation Requirements' outlined above.

d. Transaction Follow-Up — When purchase substantiation is required, you will automatically be sent a follow up letter via e-mail (or U.S. mail) requesting copies of the detailed invoice or receipt along with a completed claim form. Please review 'Substantiation Requirements' outlined above.

***Example #4* — Associate Substantiation Required** (Eligible Expense)

Your Drug Store/Pharmacy
14 W Drugstore Street, Hometown, IN 46111

Joe Jones PH: 317-555-5555
100 Main Street
Indianapolis, IN 46111
No. 1073278-05141 Date 05-01-06
Trimox 250 mg 30 Tabs No Refill
New $42.10 Your Insurance Saved You $24.35 **$17.75**

Plan: A10 Dr. D. Good
Group# 111111 Claim Reference# 11111111100010
NDC 1111-111-01 MFG **Pharmaceutical Company**

Joe Participant uses his Flex Card at the pharmacy to pay for his prescription. His prescription plan co-pay is $10.00 + 20% co-insurance for drug, so his total purchase at the pharmacy came to $17.75. Joe pays for this purchase with his Flex Card and is required to provide further purchase substantiation since the total purchase does not match exactly his applicable prescription plan co-payment. Joe would receive the transaction detail request via e-mail or by mail and simply reply by faxing or mailing copies of the detailed invoice or receipt along with a completed claim form directly to *FlexPro* for review. *FlexPro* Customer Care would determine the purchase of this prescription is an eligible expense and approve his claim. Periodic reports of Joe's claim activity

are mailed through out the plan year and Joe can view his claim activity at WWW.MBICARD.COM.

e. Ineligible Expenses — Should your transaction detail reflect your Flex Card purchase was for ineligible expenses, or if the necessary documentation was not provided to the Plan Administrator in a timely manner, the transaction will be considered 'denied/ineligible' and you must reimburse *FlexPro* for the amount charged to the Flex Card. Your Flex Card will be temporarily deactivated if reimbursement is not made immediately.

Example #5 — Associate Substantiation Required (Ineligible Expense)

Your Drug Store/Pharmacy
14 W Drugstore Street
Hometown, IN 46111
317-555-5550

1923427 Vitamin C	5.82 N	NOT FSA ELIGIBLE
Subtotal	5.82	
Tax 6.0%	0.00	
Total	5.82	
Personal Check/Credit Card	5.82	
Change Due	0.00	

Approval #123
CUSTOMER COPY

Joe Participant uses his Flex Card at the pharmacy to pay for a bottle of vitamins for $5.82 (vitamins are NOT eligible). Joe would receive the transaction detail request via e-mail or by mail and simply reply by faxing or mailing copies of the detailed invoice or receipt along with a completed claim form directly to *FlexPro* for review. *FlexPro* Customer Care would determine the purchase of vitamins was <u>not</u> an eligible expense and would then notify Joe that he must reimburse the plan for $5.82 or any future traditional claim(s) submissions would be reduced by that amount. Joe's Flex Card would be temporarily deactivated if repayment is not received immediately by *FlexPro* or sufficient eligible traditional claims are submitted to offset the ineligible Flex Card charges.

f. Non-Health Care Related Providers and Merchants

The Flex Card may not be used at Grocery Stores, Supermarkets (including Grocery Pharmacy): Walmart, Meijer, Marsh, Publix, Sav-A-Lot, Schnucks, Your Hometown Grocery/Supermarket. These merchant types are not considered health care related providers or merchants.

Example #6 — Associate Substantiation Required (Eligible and Ineligible Expense)

Hometown Grocery Store
14 Grocery Store Street
Hometown, IN 46111
317-555-5550

Rx8755552	15.00 N	FSA ELIGIBLE
1831427 Ice Mtn Water	4.09 N	NOT FSA ELIGIBLE
2288326 Tylenal Cap	12.82 T	FSA ELIGIBLE
7078511 MM Aspirin	6.44 T	FSA ELIGIBLE
9182901 Mucinex	21.88 T	FSA ELIGIBLE
3168831 Vitamin C 550ct	9.99 T	NOT FSA ELIGIBLE
Subtotal	70.22	
Tax 6.0%	3.07	
Total	73.29	
Personal Check/Credit Card	73.29	
Change Due	0.00	

Approval #5678
CUSTOMER COPY

Although the Flex Card ***may not*** be used at this merchant type category, there are many Section 125 Eligible Items that may be purchased at these merchant types. These receipts along with the completed claim form may be submitted to KBA/FlexPro for reimbursement consideration. Please review all claims 'Substantiation Requirements' before submitting claims.

4. What happens if I try to charge $50 but I only have $30 left in my available account balance?
The transaction would be denied. You may ask the provider to only charge the $30 on your Flex Card and pay the balance with another form of payment. You may check your current account balance on-line prior to using your Flex Card to verify your available balance.

5. What if my provider doesn't have a charge card terminal?
You can still utilize funds from your account using the traditional method (you pay the provider, submit a claim form and detailed invoice/receipt, and receive reimbursement via check) by mailing or faxing your claim paperwork to FlexPro.

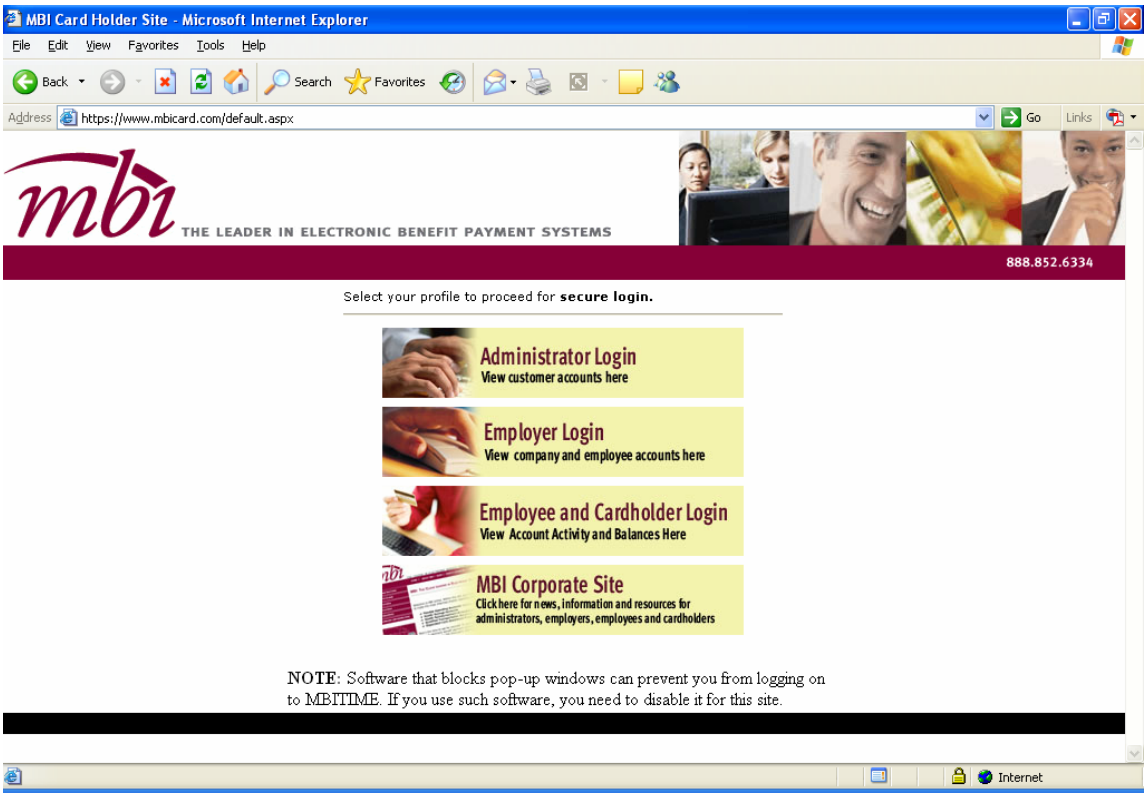
6. What do I do if my card is lost or stolen?
You should immediately contact a *FlexPro* Customer Care Representative at (800) 558-5553 and visit the web site www.mbicard.com to report your Flex Card lost or stolen. You will receive a replacement card within 7-10 days.

7. Where can I view my Flexible Spending Account history?
Go to **www.mbicard.com**. After following the instructions to 'Create Account,' you will be able to check on your current account balance, request statements on demand, and review your detailed transaction history.

Employee On-line Access to MBI – Member Account Set Up

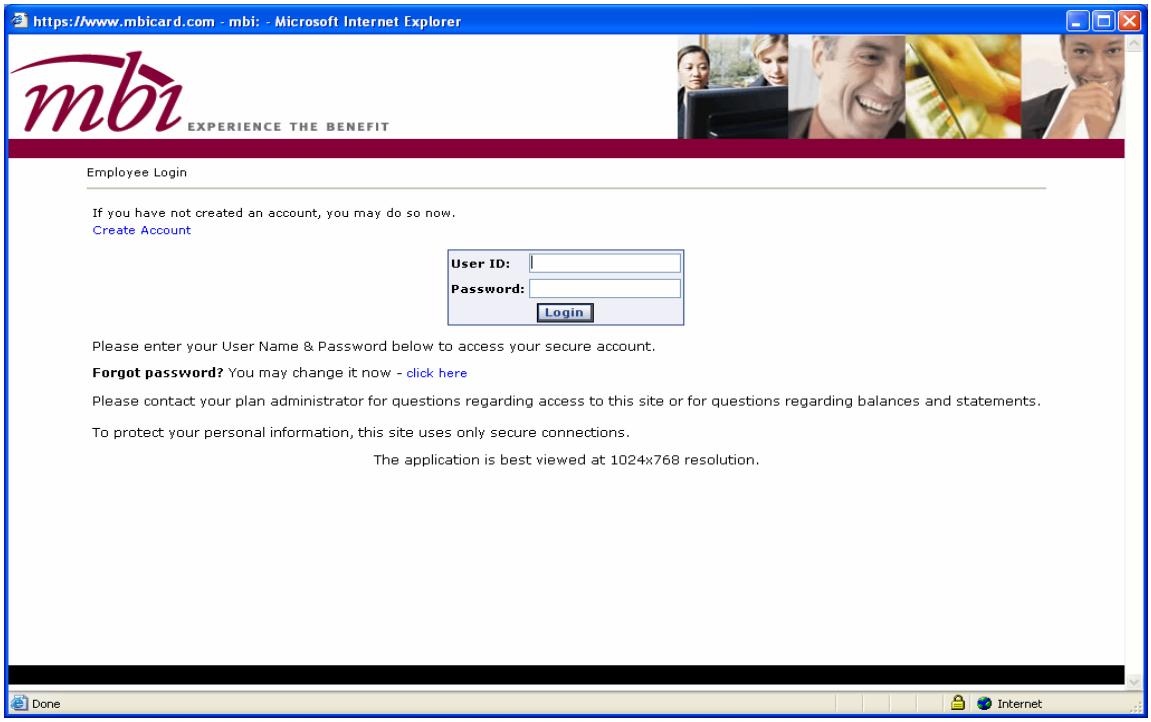
Go to: WWW.MBICARD.COM
Select Employee and Cardholder Login

Diagram #1



Select Create Account

Diagram #2



Complete the form as indicated.
See Diagram #4 for additional instructions.
Save when completed.

Diagram #3

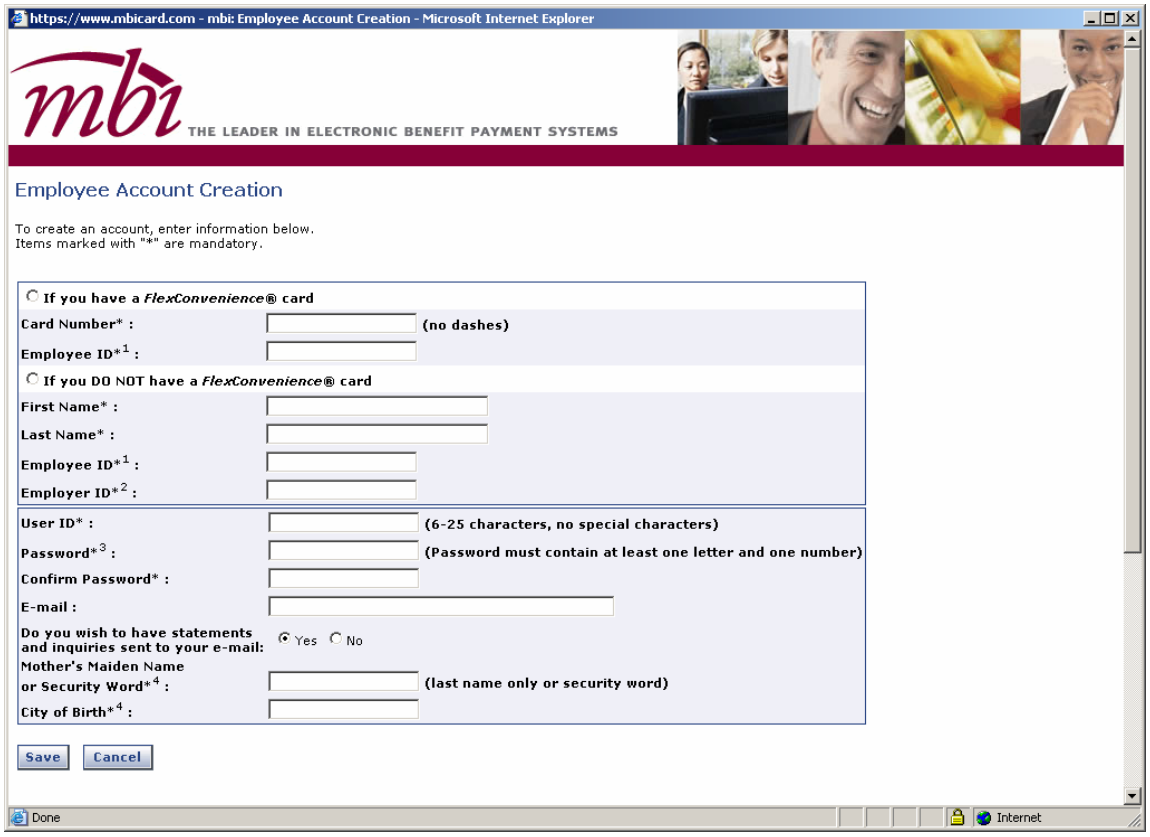
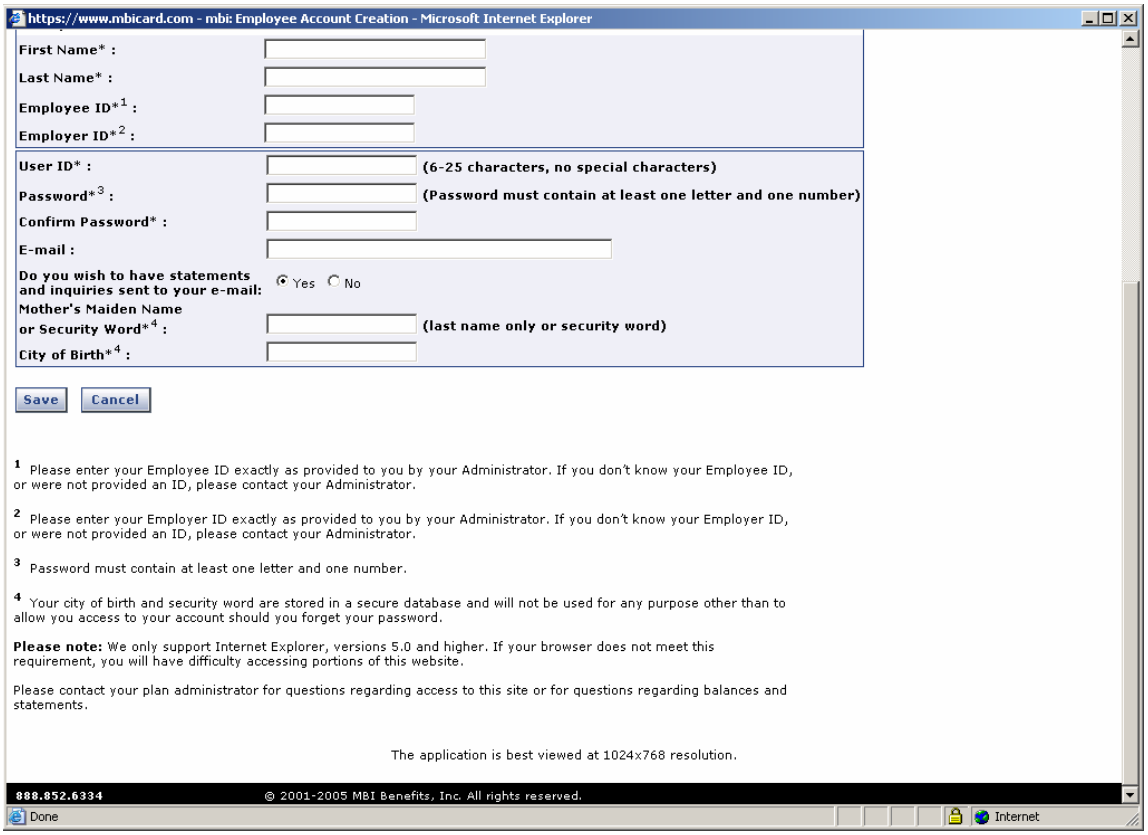


Diagram 4



State of Indiana

Section 125 *FlexPro* Plan Specifics

PLAN YEAR:	**01/01/07 - 12/31/07**
PLAN OPTIONS:	PLAN MAXIMUMS:
Premium Plan Option	Total Premiums
Health Care FSA Plan Option	$ 5,000.00
Dependent Care FSA Plan Option	$ 5,000.00
Plan Maximum	$10,000.00 + Total Premiums
PARTICIPATION IN THE PREMIUM PLAN OPTION BY NEW HIRES:	Upon eligibility
PARTICIPATION IN THE HEALTH CARE FSA PLAN OPTION BY NEW HIRES:	Upon eligibility
PARTICIPATION IN THE DEPENDENT CARE FSA PLAN OPTION BY NEW HIRES:	Upon eligibility
PARTICIPATION AFTER TERMINATION IN THE HEALTH CARE FSA PLAN OPTION:	Terminated employees will be allowed 0 days past termination to incur expenses and an additional 30 days to submit expenses.
PARTICIPATION AFTER TERMINATION IN THE DEPENDENT CARE FSA PLAN OPTION:	Terminated employees will be allowed 30 days past termination or until the end of the plan year, whichever comes first, to incur expenses and an additional 60 days to submit expenses.
CLAIMS SUBMISSION:	Claims must be submitted no later than noon E.S.T. Monday for check issuance the following Thursday.
GRACE PERIOD:	The Grace Period will allow expenses incurred within the first 74 days of this Plan Year to be reimbursed from your previous Plan Year if a balance remains in that account.
CLAIMS SUBMITTED AFTER THE END OF THE GRACE PERIOD:	Claims must be submitted no later than 90 days after the end of the Grace Period.
STATUS CHANGE NOTIFICATION TIME FRAME:	Status changes must be submitted within 30 days of the Qualifying Event

CUSTOMER CARE PHONE SUPPORT
317-284-7150 or 800-558-5553

24/7 ONLINE ACCOUNT ACCESS:
www.mbicard.com

SUBMISSION OF FLEXPRO CLAIMS:
FAX: 317-284-7269 or 866-241-1488

Key Benefit Administrators

P.O. Box 55210, Indianapolis, IN 46205

FlexPro Claim Form

THIS FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employer Name: State of Indiana - 580

Employee Name: _____ ID or SSN Number: _____

Home Address: _____
Number & Street City State Zip Code

☐ Please check if new address

Daytime Phone Number: _____ Number of pages: _____

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. If this claim includes medical expenses, I certify that these expenses have not been reimbursed, are not reimbursable from any other source, nor will any reimbursement be sought from any other source. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

Employee Signature: _____ Date: _____
Signature Required

Health Care Expenses:

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier may then be submitted to *FlexPro*™ as a qualifying receipt towards your *FlexPro*™ Plan. Health care receipts must be from an independent third party and must include the Name of the Patient, Name of the Provider, Type and date of Service or Supply provided (Names of Prescriptions are required), and the Amount of the Service or Supply. Receipts for eligible over-the-counter drugs or medicines must include the same information but the type of Supply and the Patient's Name may be hand written on the receipt by the participant if necessary.

Name of Patient or Dependent	Date(s) of Service	Name of Provider or Merchant	Type of Service or Supply	Health Care Charge for each service/supply	Flex Card Purchase Substantiation

If necessary please add additional page: **TOTAL**

Dependent Care:

Dependent Day Care receipts must include the Name of the Provider, Dates of Service, Name of the Dependent(s), Fee for Service or you may have your Dependent Day Care Provider complete and sign below (Original Signature required).

Date(s) of Service: (to & from)_____ Fee for Service: _____

Dependent(s) Name: _____ Dependent Date of Birth: _____

Dependent Care Provider Name and Tax ID #: _____

Dependent Care Provider Signature: _____ Date: _____

Attention MBI Benefits Card® Flex Card Users:

- ☐ None of the attached claims were purchased using my Flex Card
- ☐ Some of the claims were purchased using my Flex Card. Please check claim(s) purchased with your Flex Card.
- ☐ All of the attached claims were purchased using my Flex Card.

The following reimbursement request rules apply: Health Care and Dependent Care expenses must be incurred within the appropriate Plan Year. See Plan Specific page for eligibility requirements. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. *Cancelled checks are not acceptable receipts.* This form must be signed and submitted with applicable receipts.

Key Benefit Administrators P.O. Box 55210 Indianapolis, IN 46205

800-558-5553 * 317-284-7150 *** Fax: 866-241-1488 * 317-284-7269

Flexpro@Keybenefit.com

FlexPro™ Flexible Spending Account

Election Form and Salary Reduction Agreement

I. Employer: State of Indiana - 580 Effective: ____/____/____ - ____/____/____

Employee Name:_____
(Please Print) Last First Middle

_____ _____
Address Social Security Number

_____ _____
City State Zip Code Date of Birth

_____ _____
E-Mail Address Daytime Phone #

_____ _____
Number of Pay Periods Per Year Department

II. Pursuant to my Employer's Flexible Benefits Plan ("Plan"), I elect to have my salary reduced by the total pre-tax amount specified below. I authorize my Employer to apply that amount toward those plan benefits listed on this form with the total to be distributed among each benefit as shown.

Health Care Flexible Spending Accounts Expenses (# of deductions _____)
Health Care Expenses $ _____ Per Pay Period Health Care FSA
(not paid by insurance) Plan Year Total $ _____

(I understand if my spouse participates in a Health Savings Account (HSA) at his/her employer, I may not be able to participate in this general Health Care FSA.)

Dependent Day Care Flexible Spending Account Expenses (# of deductions _____)
Dependent Day Care Expenses $ _____ Per Pay Period Dependent Day Care
FSA Plan Year Total $ _____

☐ **No, I do not wish to participate in my Employer sponsored Flexible Spending Accounts.**

III. I UNDERSTAND AND AGREE THAT:

1. I cannot change or revoke my election until the next Plan Year unless my Status changes (as defined in my Employer's Plan). I understand my benefit elections may not be reduced below the amount that has been taken pre-tax as of the date of the status change.
2. Any funds remaining in my reimbursement accounts at the end of the plan year will be forfeited by IRS regulations to my employer.
3. If my employment terminates for any reason, I understand expenses must be incurred and submitted within the time frames set out in the Plan.
4. I understand that any receipt I submit must be for an eligible expense incurred during the specific Plan Year.
5. Before the first day of each Plan Year, I will be offered the opportunity to modify my elections for the following Plan Year.
6. My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan if my Employer in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue code or the regulations there under.
7. By signing and using the Flex Card, if so provided by my employer, I accept responsibility that all Card transactions will be solely for qualified expenditures incurred within the Plan Year. Each time I present the Card for payment, I will sign a receipt evidencing that the expense has been incurred and reaffirming that it is a qualified expenditure that has not been reimbursed, is not reimbursable from any other source, nor will any reimbursement be sought from any other source. Upon request, I will immediately submit any required documentation and/or transaction detail. I understand that if I use the Card for purchases other than qualified expenditures, I have violated this Agreement and my obligations under my Employer's Plan. I understand that, upon notification, I must immediately re-pay the expense to the Account and that my Card may be immediately suspended or revoked for such failure to comply. Should repayment for ineligible expenses not be remitted in a timely manner, I authorize my employer to deduct the amount from my paycheck.*

* Subject to state/local laws

Employee Signature_____**Date**_____

Key Benefit Administrators P.O. Box 55210 Indianapolis, IN 46205 800-558-5553